City of Pleasanton Community Services

Summer Day Camps

Emergency Medical Release and Identification Form

FAMILY INFORMATION

Child's name (last name, first): _____ Birth date: _____

Mother's Name: _____ Lives with child YES NO

Mother's Address: _____ Home Phone (____)_____

Father's Name: _____ Lives with child YES NO

Father's Address: _____ Home Phone (____)_____

Mother's Company Name: _____ Work Phone (____)_____Ext._____

Company Address: _____ Cell Phone _____

_____ Pager #_____

Father's Company Name: _____ Work Phone (____)_____Ext._____

Company Address: _____ Cell Phone _____

_____ Pager #_____

E-mail Address: _____

PHYSICIAN TO BE CALLED IN EMERGENCY

Name _____Telephone (___)_____

Address_____

Medi-Cal Number _____Medical Insurance _____ Insurance Number_____

DENTIST TO BE CALLED IN EMERGENCY

Name _____Telephone (___)_____

Address_____

Medi-Cal Number _____Dental Insurance _____ Insurance Number_____

Food Allergies (life threatening)_____

*If your child has a life threatening food allergy contact the Preschool Office **IMMEDIATELY** at 931-3430 to complete the Emergency Action Plan Form .for Allergies*

Food Restrictions (non life threatening)_____

Other Medical Limitations or Special Needs: _____

Consent to Medical Treatment of Minor

I hereby authorize any medical doctor, emergency medical technician, paramedic, nurse, healthcare provider, hospital, or other medical facility to treat my child for any illness, medical complication, allergic reaction, or injury received while my child participates in the Summer Day Camp Program. I authorize any licensed physician to perform any procedure, including the administration of anesthesia, that the physician deems advisable to treat any illness, medical complication, allergic reaction, or injury that my child may experience. I authorize any City of Pleasanton employee to perform any procedure, including the administration of epi-pens or medication (whether over the counter or prescription) that I have describe in the Emergency Action Plan Form for Life Threatening Allergies/Medical Condition to treat any illness, medical condition, allergic reaction, or injury that my child may experience. I realize that there is a possibility of complications and undesired and unforeseen consequences in any medical treatment and I assume any such risk on behalf of my child.

I represent that I am a parent or legal guardian of the child and I hereby agree to defend, hold harmless, and indemnify the City of Pleasanton, its Council, officers, employees, agents, and volunteers, and event holders, event sponsors, event directors, event volunteers, doctors, emergency medical technicians, paramedics, nurses, healthcare providers, and hospitals or other medical facilities from all liability, loss, costs, claims, or damages whatsoever that may be imposed upon said parties due to the medical treatment, or lack thereof, given to my child.

I have read this release, understand its legal implications, and agree to its terms.

Parent/Guardian Signature: ______ Date _____

Print Name: _____

If you have any questions regarding this form, please call the City Attorney's Office at (925) 931-5015. **revised 10/15/04**